Children's Advocate Report

A Summary of Child Death Reviews for the Years 2000 and 2001

The Saskatchewan Children's Advocate Office

March 2005

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Page 16 and 17

Figure 2. Number of Deaths of Children From Birth to 21 Years of Age in Saskatchewan; CAO Deaths Reviewed and Total Provincial Deaths, 2000

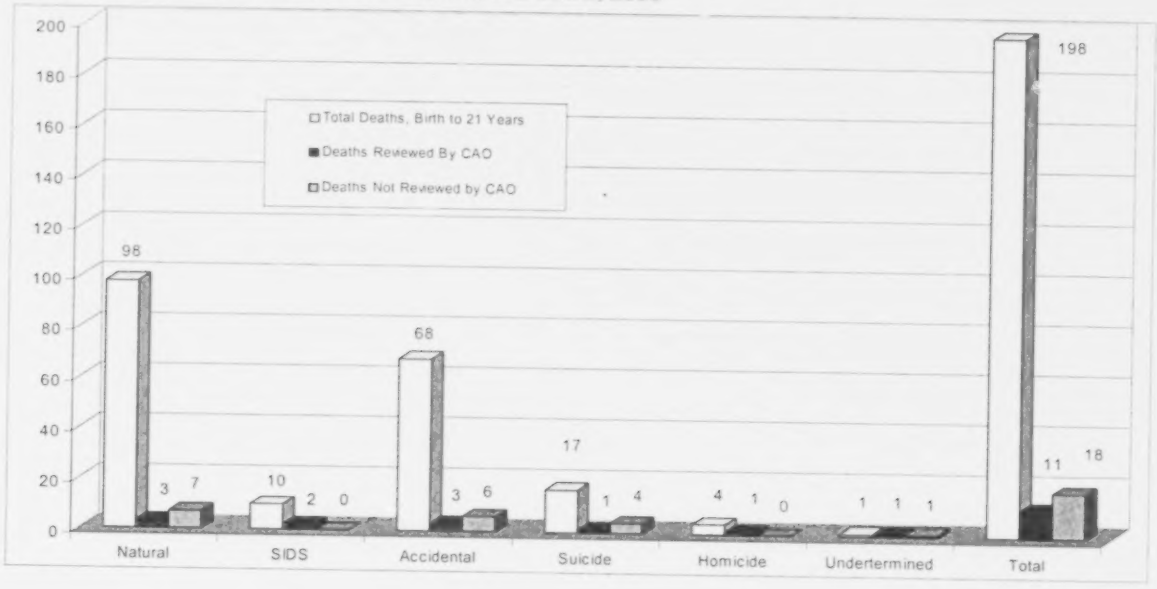
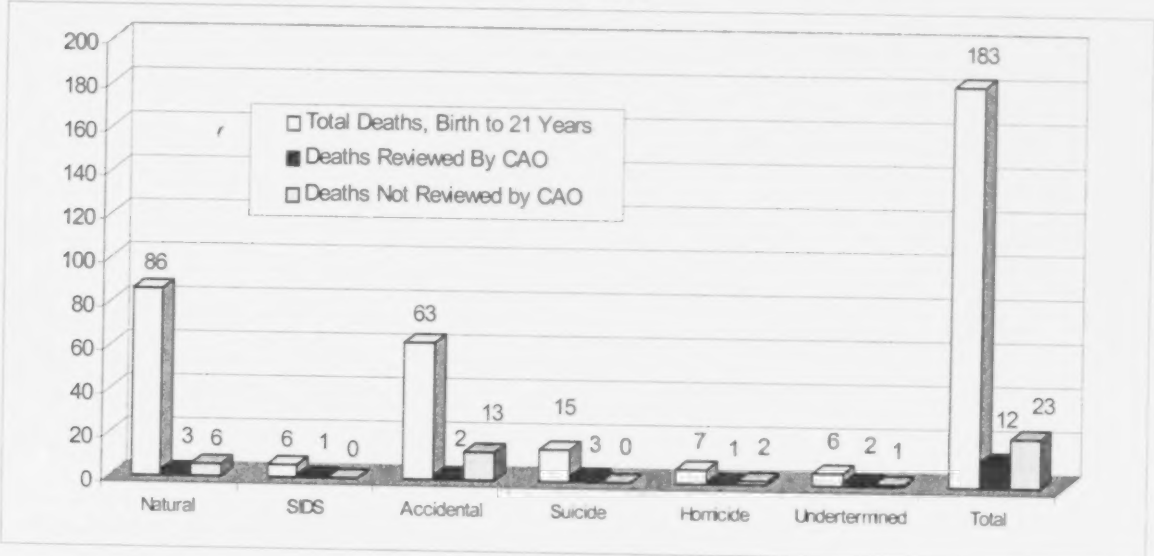


Figure 3. Number of Deaths of Children From Birth to 21 Years of Age in Saskatchewan; CAO Deaths Reviewed and Total Provincial Deaths, 2001



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The Children's Advocate is an officer of the Legislative Assembly of Saskatchewan and acts pursuant to *The Ombudsman and Children's Advocate Act*. The reviews contained in this report were conducted and this report is published in accordance with this legislation.

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Executive Summary

Thousands of children and young people each year[1] receive services from government departments and agencies and, for the most part, these services are supportive and helpful to them. The review of child[2] deaths is one of the many methods the child-serving system uses to identify ways to better serve Saskatchewan children.

This report provides a summary of the issues found in the reviews of 23 children who died in 2000 and 2001. In addition, the report includes the reviews of two 1999 deaths that were not presented in *A Summary of Child Death Reviews for the Year 1999*. The Children's Advocate Office (CAO) has now reviewed the deaths of 117 children who died between August 1996 and December 31, 2001.

The Departments of Community Resources and Employment (DCRE)[3] and Corrections and Public Safety (CPS) internally review the deaths of all children, who were, at the time of their death or in the six months previous to their death, in the care of the Minister of DCRE or CPS, receiving services pursuant to Section 10 of *The Child and Family Services Act* or the *Young Offenders Act* or receiving other services from DCRE or CPS. The DCRE requested an external review by the CAO on 23 of the deaths that occurred in 2000 and 2001. Where the deaths were sudden and unexpected, the Chief Coroner also notified the CAO of the deaths.

This report examines the deaths of a limited number of our most vulnerable children. The CAO reviewed 5.6 percent of the deaths of all Saskatchewan children (under age 22) in 2000 and 6.6 percent of all the deaths in 2001. Of the 25 child death reviews included in this report (2 in 1999, 11 in 2000 and 12 in 2001), 14 were in the care of the Minister of DCRE or CPS when they died (0 in 1999, 5 in 2000 and 9 in 2001). Of the 14 children who died while living in the care of the Minister, six died of natural causes, three deaths were accidental, three deaths were suicides, and two deaths were SIDS deaths .

Eleven of the deaths reviewed in this report were children who were not in the care of a Minister when they died (2 in 1999, 6 in 2000 and 3 in 2001). Of these 11 children, three deaths were classified as accidental, two deaths were from natural causes, one death was a suicide, two deaths were homicides, one death was a SIDS death and the causes of two deaths were undetermined.

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[1] Each year, the DCRE provides services to children and youth residing in their own homes, with extended family, in foster care and other arrangements through a variety of program options. For a complete breakdown of the numbers of children and families receiving services from the DCRE please refer to Part 6 of this report (pages 18-20) and Appendix D (page 46).

[2] Throughout this report the term child(ren) is used to refer to anyone under the age of 18 and includes a person 18 years of age or more as defined in *The Ombudsman and Children's Advocate Act*.

[3] Note: The Department of Social Services was renamed the Department of Community Resources and Employment (DCRE) in April 2003. As the reviews included in this report were completed after the change in name, and therefore all correspondence and recommendations were sent under the new name, the new name has been used for the purposes of this report. However, it should be noted that officially during the time frame for the deaths, 2000-2001, the children noted in this report were receiving services from the Department of Social Services.

Individual issues concerning the services provided to these children were brought to the attention of the DCRE or CPS as well as other appropriate departments and agencies. This report provides an update on any recurring issues identified in either the 1996-1998 Summary Report or the 1999 Summary Report and identifies new issues that emerged from this set of reviews.

Themes/Issues

The issues raised through the review of the 2000 and 2001 child death reviews and the two 1999 child death reviews are:

1. Assessment and Intervention

The CAO identified concerns regarding assessment and intervention in nine of the 23 child death reviews from 2000 and 2001. Concerns regarding assessment and intervention were also present in both of the 1999 child death reviews. The majority of these concerns did not result in recommendations, as policy already exists in this area. The CAO raised the issues as practice concerns. In one file, the CAO made two recommendations regarding the unique needs of immigrant children. In five files, the CAO found that the DCRE did not follow best practice standards outlined in policy regarding appropriate assessment and intervention. Two recommendations were made regarding this issue.

2. Approval of Placements

In four of the 14 2000 and 2001 child death reviews where the children were in the care of the Minister, the CAO identified placement concerns. These reviews involved children who had been placed in the care of the Minister prior to their death. In three reviews, the CAO found that the DCRE placed children in resources without adequately evaluating issues within the resource that compromised the care or safety of children. Two recommendations were made regarding this issue.

3. Need for Integrated Case Management

Eight of the 23 2000 and 2001 child death reviews and both of the 1999 child death reviews identified concerns regarding a lack of integrated case management services. In addition, the CAO found that there was a need for increased communication between the various government departments and agencies involved with each of these reviews. Five recommendations were made regarding the need for improved coordination and communication between departments and agencies.

4. Information Management

In seven of the 23 2000 and 2001 reviews, the CAO identified problems with information management, including sharing information, accessing information, storing information, and recording information.

5. Medical Services

In one review, the CAO identified systemic concerns regarding diagnostic imaging when multiple hospitals are involved.

Update from the 1999 Summary Report

In December 2003, the CAO reported in *A Summary of Child Deaths for the Year 1999* on a number of options for changing the child death review processes in Saskatchewan. An update on these issues is provided below:

File Audits to Review Compliance with Case Practice

Similar to the 1999 Summary Report, the CAO continued to observe gaps between government policy and practice in some of the deaths from 2000 and 2001. In December 2003, the CAO requested that the DCRE provide the CAO with the results of their annual file audits. The CAO also requested that the DCRE publicly release the results of these file audits.

The DCRE has subsequently developed and implemented a very comprehensive and commendable Quality Improvement Plan. The DCRE reported some general trends in their compliance results (increases and decreases) for 2003 in their 2003-2004 Annual Report. The measures taken to date are moving towards the increased transparency and accountability that the CAO requested of the DCRE in 2003. The CAO is hopeful that more specific results will be reported publicly in upcoming Annual Reports.

Review All Child Deaths

In the 1999 Summary Report, in accordance with *The Ombudsman and Children's Advocate Act*, the CAO recommended: "That government develop a model to ensure all child deaths are reviewed by 'an educated eye' and that this model begin to be implemented by January 1, 2005."

To date, there is still no mechanism in Saskatchewan to review the deaths of all children. However, Saskatchewan Health has indicated to the CAO that they "will continue to work in partnership with other Departments and agencies: to more fully explore the operational, jurisdictional and legislative implications of an expanded child death review; to consider the mandates and roles of the Chief Coroner's Office and the Children's Advocate Office in that respect; and to assess the extent to which the additional information obtained through an expanded review will contribute to the objective of reducing children's deaths."

Part 1
Introduction

The Children's Advocate Office (CAO) in Saskatchewan conducts comprehensive reviews of the deaths of a limited number of children[1]. The reviews offer observations, findings and recommendations designed to prevent child deaths, impact child-serving systems and promote public accountability. These particular child deaths are reviewed due to the nature of the child's involvement with government and are one means for public accountability in relation to child welfare and young offender services.

The CAO recognizes that in addition to child death reviews, there may be more effective ways to achieve the goals of preventing child deaths and impacting the child-serving systems. Based on this belief, in *A Summary of Child Deaths for the Year 1999*, the CAO called on the government to make changes to the way in which child deaths are reviewed in Saskatchewan.

First, the CAO requested that the Department of Community Resources and Employment (DCRE)[2] publicly release the results of their clearly defined and carefully measured quality assurance mechanisms. The second was that the CAO would be committed to continue to conduct comprehensive independent reviews of those child deaths where the child was in government care. Thirdly, the CAO, in accordance with *The Ombudsman and Children's Advocate Act*, recommended: "That government develop a model to ensure all child deaths are reviewed by 'an educated eye' and that this model begin to be implemented by January 1, 2005."

Since December 2003 when the CAO released the 1999 Summary Report, several changes have been made.

1. The DCRE and CPS implemented new child death review policies in March 2004. These changes in policy have been applied to the CAO review of deaths that occurred after January 1, 2000.

2. In December 2003, the DCRE agreed to release the results of its quality assurance audits within one year. The DCRE has subsequently developed and implemented a very comprehensive and commendable Quality Improvement Plan. The DCRE has provided the CAO with the results of their internal annual file audits and has undertaken a process to publicly report on their performance using a variety of venues.

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[1] Throughout this report the term child(ren) is used to refer to anyone under the age of 18 and includes a person 18 years of age or more as defined in *The Ombudsman and Children's Advocate Act*.

[2] Note: The Department of Social Services was renamed the Department of Community Resources and Employment (DCRE) in April 2003. As the reviews included in this report were completed after the change in name, and therefore all correspondence and recommendations were sent under the new name, the new name has been used for the purposes of this report. However, it should be noted that officially during the time frame for the deaths, 2000-2001, the children noted in this report were receiving services from the Department of Social Services.

3. To date, there is still no mechanism in Saskatchewan to review the deaths of all children. However, Saskatchewan Health has indicated that they "will continue to work in partnership with other Departments and agencies: to more fully explore the operational, jurisdictional and legislative implications of an expanded child death review; to consider the mandates and roles of the Chief Coroner's Office and the Children's Advocate Office in that respect; and to assess the extent to which the additional information obtained through an expanded review will contribute to the objective of reducing children's deaths."

Further to the three issues noted above, the 2000 and 2001 child death reviews highlighted the need for government to continue to be diligent with respect to previously identified issues as well as new areas of concern. This report contains 14 new recommendations and three previously made recommendations. This is the fourth child death review report made by the CAO to government and in this report, we have built on the insights gained from our review of deaths from 1996 forward.

To date, the CAO has completed the reviews of the deaths of 117 children and has made 77 recommendations to government. These recommendations are focused on developing a stronger child serving system where practices reflect the policies and standards that are in place. The DCRE, CPS and other government departments and agencies respond to the recommendations made by the CAO. In the majority of cases the recommendations are either implemented or other actions are taken to address the issues identified. Following each recommendation in this report, the CAO has provided the appropriate department or agency's response and progress with respect to each recommendation.

It is our hope that this report adds to our growing understanding of the services provided to this small group of children and youth. We have attempted to be sensitive to this throughout this report and want to sincerely thank all of the government staff, community members, family members and others who have assisted us to complete these reviews.

Part 2
Authority

Children's Advocate Authority and Mandate

The Children's Advocate is an officer of the Legislative Assembly of Saskatchewan and acts pursuant to *The Ombudsman and Children's Advocate Act*. The mandate of the Children's Advocate is to promote the interests of, and act as a voice for children when there are concerns about provincial government services. The Children's Advocate engages in public education, works to resolve disputes, and conducts independent investigations. The Children's Advocate also recommends improvements to programs for children to the government and/or the Legislative Assembly of Saskatchewan. The vision of the Children's Advocate Office is to ensure that the interests and well-being of children are respected and valued in our communities and in government practice, policy and legislation.

Section 12.6 inter alia of *The Ombudsman and Children's Advocate Act* provides that:

(2) The Children's Advocate shall:
- (a) become involved in public education respecting the interests and well-being of children;
- (b) receive, review and investigate any matter that comes to his or her attention from any source, including a child, concerning:
  - i) a child who receives services from any department or agency of the government;
  - ii) a group of children who receive services from any department or agency of government; and
  - iii) services to a child or to a group of children by any department or agency of the government;
- (c) where appropriate, try to resolve those matters mentioned in clause (b) that come to his or her attention through the use of negotiation, conciliation, mediation or other non-adversarial approaches; and
- (d) where appropriate, make recommendations on any of those matters mentioned in clause (b).

The Ombudsman and Children's Advocate Act, Saskatchewan, Revised 2000.

Authority to Conduct Child Death Reviews

Child Death Reviews (CDRs) are conducted by the CAO in accordance with the legislated mandate of the Children's Advocate. Section 12.6 (2)(b)(iii) states that the Children's Advocate shall "receive, review and investigate any matter that comes to his or her attention from any source, including a child, concerning services to a child or to a group of children by any department or agency of the government." The Children's Advocate has the authority to require any person to provide information, documents or things regarding any matter being investigated. She is further authorized to summon and examine under oath any person who is able to provide information relating to the matter being investigated.

Part 3
Background

The Department of Community Resources and Employment (DCRE, previously the Department of Social Services) first established a child death review policy in 1992. Due to the need for increased public accountability, the DCRE and the CAO recognized that independent and publicly accountable reviews of child deaths were required. In November 1996, the DCRE adopted a new child death review policy. The intent of the policy was "to satisfy the department's need to be accountable in the services provided to children, youth and families, and to ensure that the public interest in protecting children and youth is met." (Saskatchewan Social Services, 2000, February-Revised).

In order to meet the need for independent external reviews of child deaths, a protocol was established between the CAO and the DCRE. The CAO agreed to provide the independent, external reviews of the death of a child when a referral was made by the DCRE. The DCRE agreed to make referrals where the department wanted their services reviewed by an external party, as another way for the department to be accountable for the services that they provide. The reviews would examine the deaths of children who were, at the time of their death or in the 12 months preceding their death, receiving services from the DCRE pursuant to *The Child and Family Services Act*, or the *Young Offenders Act* (replaced by the *Youth Criminal Justice Act* in April 2003), or were attending a facility or a family child care home licensed under *The Child Care Act*. This initial agreement was for the CAO to review the deaths of the three or four children per year that the DCRE identified as particularly complex. However, this protocol was expanded to include a review of approximately 30 deaths per year and had the effect of widening the child death review policy.

Following the release of the 1999 Summary Report, and in accordance with the need for changes as identified by the CAO and the DCRE, the CAO and the DCRE finalized a new process to review child deaths. The revised Death of a Child/Youth Review Policy was finalized in March 2004.

Part 4
Process for Conducting a Child Death Review (CDR)

2000-2001 CDR Process

Prior to requesting a review by the CAO, the DCRE policy indicates "A Departmental Review will be conducted and a Serious case Incident Reoprt completed (....) in all cases where a child or youth dies and the child, youth or family received services pursuant to *The Child and Family Services Act*" (DCRE, Family-Centred Services Policy and Procedures Manual, March 2004). Therefore the DCRE reviews the deaths of all children who were in the care of the Minister or where a youth was receiving services pursuant to Section 10 of *The Child and Family Services Act* at the time of their death or in the six months previous to their death, to determine which files will be referred for external review.

According to the March 2004 Revised Saskatchewan Community Resources and Employment, Death of a Child/Youth Review Policy, the CAO receives notice of the deaths of all children who were in the care of the Minister, or where a youth was receiving services pursuant to Section 10 of *The Child and Family Services Act* at the time of their death or in the six months previous to their death. The DCRE requests an external review from the CAO:

- In all cases where a child was in the care of the Minister or where a youth was receiving services pursuant to Section 10 of *The Child and Family Services Act* at the time of their death or in the six months previous to their death.
- In recommending an external review in circumstances other than those outlined above, the Regional Director will take into account the nature, frequency and intensity of services and the degree of connection between the child's death and the department's responsibility to provide services that protect the child. (Saskatchewan Community Resources and Employment, 2004, March-Revised).

In May 2003, the Department of Correction and Public Safety (CPS) also developed a review policy for the "event of the death of a young person who, at the time of death, is receiving services pursuant to the *Youth Criminal Justice Act* (YCJA), or the *Young Offender Act* (YOA)" (CPS, Policy Statement, May 2003). This policy outlines the procedures for the referral of such deaths for external review by the CAO.

The CAO also reviews any other matter that is referred to the Office, including child deaths, in accordance with *The Ombudsman and Children's Advocate Act*. Where the deaths were sudden and unexpected, the Chief Coroner also notifies the CAO of the deaths. Prior to commencing a review, the CAO sends a notice of investigation to the DCRE, pursuant to section 20(1) of *The Ombudsman and Children's Advocate Act*. The CAO child death review process includes an examination of:

- the DCRE or CPS Departmental Review - An internal review that examines the services provided by the region or agency to that child and his or her family;
- the information provided by the Coroner's Branch, Saskatchewan Justice;
- the original DCRE or CPS file materials; and
- relevant information/material from additional service providers/agencies.

Staff are also interviewed where clarification is required. The services provided are examined for consistency with existing practice, policy and legislation.

In March 2002, the CAO created a Multi-Disciplinary Review Team (MDRT)[4] to advise and assist the CAO with the review of child deaths. The MDRT was assembled to maximize the potential for improvements to child serving systems in Saskatchewan. This eight-person team (Appendix A):

- Advises on tentative findings and recommendations,
- Identifies and describes systemic and cross-jurisdictional issues, and
- Proposes strategies for prevention.

The MDRT is comprised of representatives who are invited by the Children's Advocate to participate, for a fixed term, on the MDRT. The current members include physicians, educators, lawyers, former police officers, social workers and youth from care. The Chief Coroner is also a member of the MDRT.

CAO staff complete a comprehensive report detailing the services provided to each child and the circumstances of the child's death, and prepare an analysis. The MDRT reviews this report and provides its analysis and recommendations.

The CAO then provides tentative observations, findings and recommendations to the appropriate departments or agencies, or where appropriate, a person. In accordance with section 21(3) of *The Ombudsman and Children's Advocate Act*, the CAO provides these departments, agencies or persons, with the "opportunity to make representations in respect of the matter." Individual files are concluded following receipt of the department or agency's responses to the tentative findings and recommendations.

CDR Recommendations

The CAO has reviewed the deaths of 117 children who died between August 1996 and December 31, 2001. The CAO has made 77 recommendations in the review of these deaths. This report contains 17 recommendations (14 new recommendations) to various government departments and agencies on ways to improve services to children. The DCRE, CPS and other government departments and agencies respond to the recommendations made by the CAO. In the majority of cases the recommendations are either implemented or other actions are taken to address the issues identified. Following each recommendation in this report, the CAO has provided the appropriate department or agency's response and progress with respect each recommendation.

Each recommendation is numbered in succession with the year that the recommendation is made noted in brackets. If the same recommendation is made on more than one file, or in more than one year, it is given the same CDR number and the new year is added; for example, CDR.31(97,99). See Appendix C for a complete list of all CAO CDR recommendations. (Note: where a recommendation contained information that would identify the child, the information was removed from the public recommendation.)

[4] The MDRT was established in response to the Guiding Principles for Child Death Review adopted by the Federal/Provincial/Territorial Working Meeting on Child Death Review in June 2000. One of the national core principles for effective child death review work is to ensure that a multi-disciplinary approach is used. In the 1996-1998 Summary Report, the CAO primarily reported on the concerns identified in the child welfare service delivery system. The CAO multidisciplinary review of the 1999 deaths provided the CAO with the opportunity to review the practice of other departments and agencies.

Part 5
This Report

Which Children are Included in this Report?

As in the past, for the years 2000 and 2001, the CAO received notice of the deaths of all children who were, at the time of their death or in the 12 months preceding their death, receiving services from the DCRE pursuant to *The Child and Family Services Act*, or the *Young Offenders Act* (replaced by the *Youth Criminal Justice Act* in April 2003). This resulted in the CAO receiving notification of the deaths of 30 children in 2000 and 34 children in 2001. In addition, the CAO received one community referral for one death in 2001. Thus, the CAO received notification of the death of 65 children that died between January 1, 2000 and December 31, 2001.

Due to the 2003 and 2004 changes in the DCRE and CPS Death of a Child/Youth Review Policies, the CAO agreed to apply the updated policy to all deaths occurring after January 1, 2000. As a result, there were several deaths where the CAO received notification, which no longer met the requirements for a review. Therefore, reviews were not conducted and the files were closed on 18 deaths in 2000 and 23 deaths in 2001. For comparison purposes, statistical information that was available on these deaths is included in Part 6 of this report. For each file that no longer met the requirement for an external review, according to DCRE policy, a department review was conducted for "all cases where a child or youth dies and the child, youth or family received services pursuant to *The Child and Family Services Act*" (DCRE, Family-Centred Services Policy and Procedures Manual, March 2004).

Prior to requesting a review by the CAO, the DCRE and CPS review the deaths of all children who were in the care of the Minister or where a youth was receiving services pursuant to Section 10 of *The Child and Family Services Act* at the time of their death or in the six months previous to their death, to determine which files will be referred for external review.

In accordance with the new policy, the CAO completed reviews of the deaths of 11 children who died in 2000 and 12 children who died in 2001. One child death review for the year 2000 has not been concluded and is therefore not included in this report.

In addition, this report includes two child death reviews that were completed for children who died during 1999. At the time of the 1999 Summary Report, these reviews were not finalized in one case due to the jurisdiction of the CAO to obtain required information and in the other case the DCRE had not yet provided the CAO with the regional review. The CAO findings and recommendations for both deaths are included in this report.

It should also be noted that in April 2002, the Department of Corrections and Public Safety (CPS) was created and the responsibility for young offenders services was transferred to CPS. However, in 2000 and 2001, the DCRE had responsibility for these services. Two of the 12 reviews completed for 2001 were for youth receiving services that would today be the sole responsibility of CPS; one review from 2000 and another one from 2001 would have come under the jurisdiction of both DCRE and CPS.

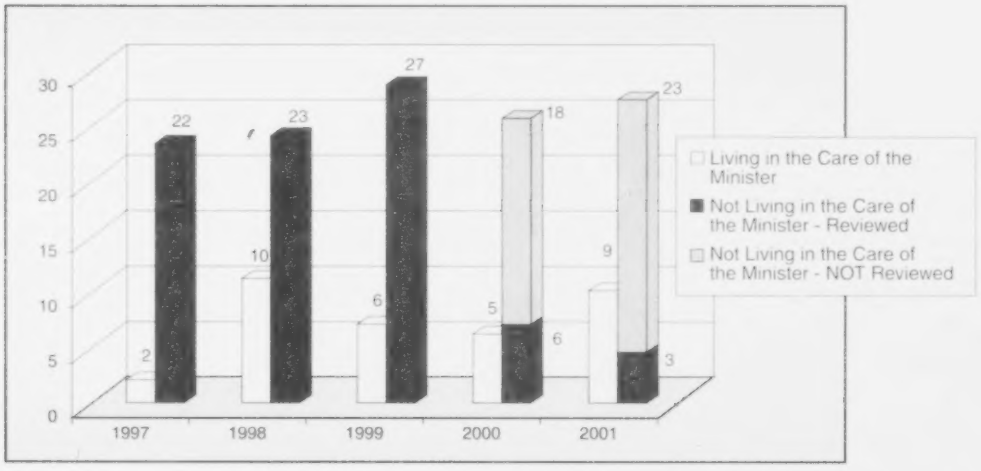
Part 6
General Findings

Notification of Child Deaths in 2000 and 2001

Of the 64[1] deaths that occurred in years 2000 and 2001, the following is known:

- 42 children were male, while 22 were female
- 24 children were status First Nations children; three children were non-status First Nations children; five were Metis; eight were non-aboriginal; and 24 children were of Aboriginal ancestry, however the constitutional status for these children was unknown
- 17 were in the care of the Minister of Community Resources and Employment at the time of their death, while 47 were receiving services from the DCRE at the time of their death or in the 12 months preceding their death. (Note: Two of these children were not in care under *The Child and Family Services Act*, but were in open-custody facilities receiving services pursuant to the *Young Offenders Act*. Young offender services were the responsibility of the Department of Social Services in 2000 and 2001; therefore in this report the CAO has reported these deaths as "in the care of the Minister" at the time of their deaths).
- In the 2000 and 2001 child deaths, the leading cause of death was by Accident (24). The second leading cause of death was Natural Cause (18), followed by Suicide (8), Sudden Infant Death Syndrome (SIDS) (5), and Homicide (4). The cause of death was Undetermined in four cases and Unclassified in one case

Figure 1. CAO Child Death Reviews showing Type of Care Arrangement with the Minister of Community Resources and Employment. 1997 to 2001 N=154[1]



[1] Note. The number of children Not in Care of the Minister was increased by two in 1999 from the numbers reported in the 1999 Summary Report to reflect the two child death reviews that were concluded since the 1999 Summary Report. Of these two 1999 deaths, both were male, both were status First Nations children; both were living in their parental homes at the time of their deaths.

[1] This section contains information on 64 deaths that occured in 2000 and 2001 as opposed to the 65 deaths that the CAO received notication on (as identified in the first paragraph on page 13), as one child death review for the year 2000 has not been concluded and is therefore not included in the analysis secions of this report.

Who are the Children who's Deaths were reviewed in 2000 and 2001?

Of the 23 child deaths that were reviewed for the years 2000 and 2001, the following is known:

- 16 children were male, while 7 were female
- 12 children were status First Nations children; two children were non-status First Nations children; two were Metis; three were non-aboriginal; and four children were of Aboriginal ancestry, however the constitutional status for these children was unknown
- 14 were in the care of the Minister of Community Resources and Employment at the time of their death, while nine had been in the care of the Minister in the six months previous to their death or was a youth receiving services pursuant to Section 10 of *The Child and Family Services Act* or the *Young Offenders Act*

Causes of Death/ Classifications of Death

For the 23 deaths reviewed for the years 2000 and 2001, the leading cause of death was by Natural Causes (7). The second leading cause of death was Accident (5), followed by Suicide (4), Sudden Infant Death Syndrome (SIDS) (3) and Homicide (2). The cause of death was Undetermined in two cases.

Chief Coroner uses five classifications of death:

- A ***Natural*** death is one primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental conditions.
- An ***Accidental*** death is a death due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident. (This includes injury from chemicals, including alcohol and drugs).
- A ***Suicidal*** death is one that results from self-inflicted injury, with intent to cause death.
- A ***Homicidal*** death is a death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.
- An ***Undetermined*** death is one which, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide or homicide.

(Source: The Office of Chief Coroner, 2003)
Note: While the Chief Coroner includes deaths attributed to SIDS in the classification of Natural deaths, for the purposes of this review the CAO has listed the SIDS deaths as a separate category.

Natural Causes

Of the seven children that died of natural causes, five of the children were previously identified as "failure to thrive" or medically fragile, one of whom had a congenital anomaly. Each of these five children was three years of age or younger. One infant and one ten-year old child died from pneumonia.

Accidents

Of the five children that died due to accidental causes:

- two died in fires
- one drowned
- one died as the result of a gunshot wound to the chest
- one died from disease and organ failure as a result of complications from FAS

Suicide
Of the four suicide deaths, all four children/youth died from asphyxiation due to hanging. The average age was 17 years.

SIDS
As noted earlier, the Chief Coroner includes deaths attributed to SIDS in the classification of Natural Causes. For the purposes of this review, the CAO has listed the SIDS deaths as a separate category. During 2000-2001, three deaths were attributed to SIDS.

Homicide
Of the two homicide deaths, one was a 14-month-old child who died as a result of a blunt trauma, while the other was an 18-year-old youth who died as a result of a stabbing.

Undetermined
Two causes of death were undetermined.

Comparison to Provincial Child Deaths

The 23 deaths reviewed by the CAO represent a fraction of the total number of children who died in Saskatchewan during the reporting period. In 2000, a total of 198 children and youth under the age of 22 died in Saskatchewan. In 2001 a total of 183 children and youth died. The CAO reviewed 11 of these 2000 deaths, representing 5.6 percent of the total provincial child deaths and 12 of the 2001 deaths representing 6.6 percent of the total provincial child deaths. Figure 2 compares the number of provincial child deaths by cause of death with the deaths reviewed by the CAO during 2000. Figure 3 compares the number of provincial child deaths by cause of death with the deaths reviewed by the CAO during 2001. Table 1 (Appendix B of this report) provides a numerical representation of this data. (Note: the data on child deaths for the years 1997, 1998, 1999, as well as on the deaths that were not reviewed has also been included for comparison purposes).

Figure 2. Number of Deaths of Children From Birth to 21 Years of Age in Saskatchewan; CAO Deaths Reviewed and Total Provincial Deaths, 2000

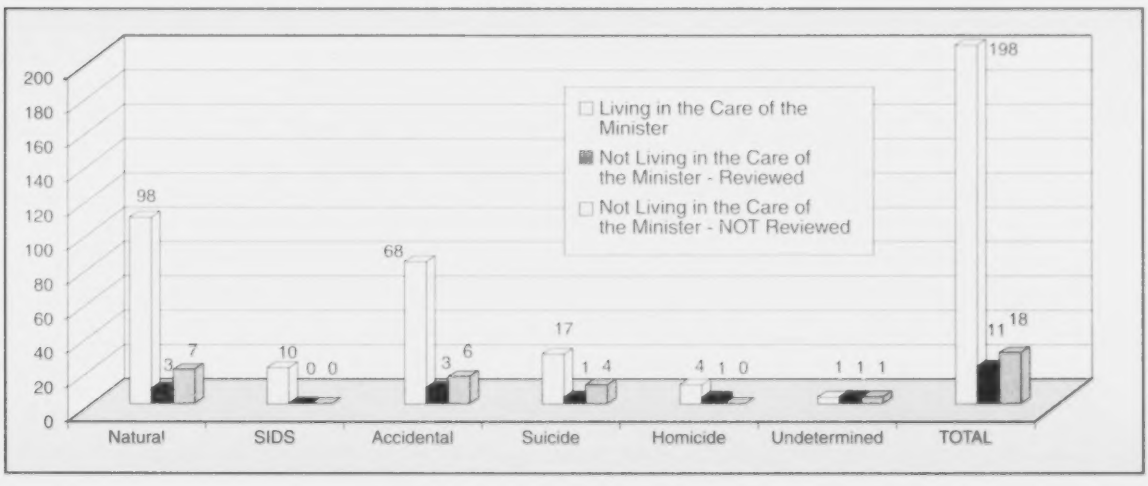
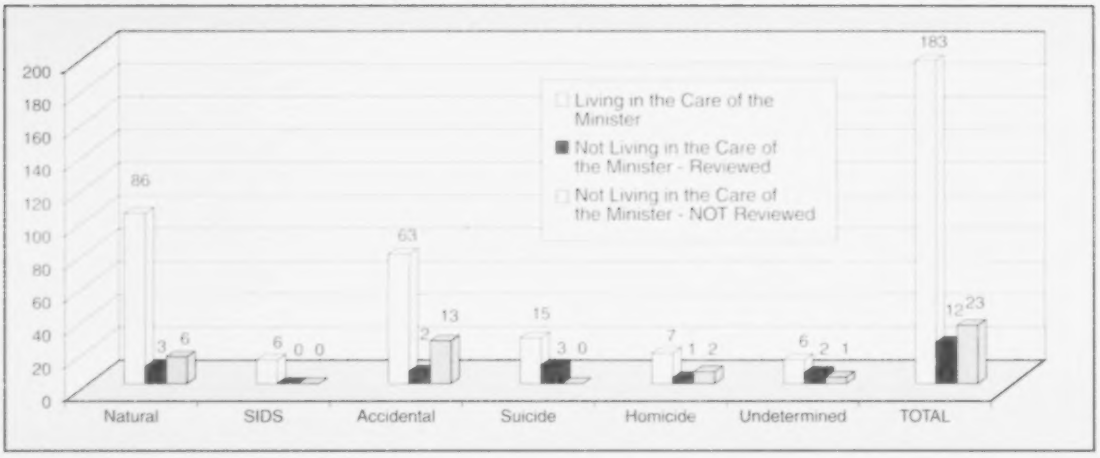


Figure 3. Number of Deaths of Children From Birth to 21 Years of Age in Saskatchewan: CAO Deaths Reviewed and Total Provincial Deaths, 2001



[1] Source for Figures 2 and 3: Saskatchewan Health, Corporate Information and Technology Branch (Provincial data for 1997, 1998, 1999 prepared with the assistance of the Saskatchewan Institute on Prevention of Handicaps, 2003.) Source for 2000 and 2001 provincial data was the Saskatchewan Vital Statistics Interim Data Set provided by Saskatchewan Health, Health Information Solutions Centre (February 2005) and includes deaths of Saskatchewan residents, aged 21 and under, occurring in Saskatchewan.

[2] For provincial data, includes sudden deaths of infants, cause unknown.

[3] In Figure 3, for the Year 2001, the total number of deaths where the CAO received notification of the death, but did not review the death due to the change in the DCRE policy was 23. One death does not appear in the sub-categories of causes of death in figure 3 as the death was Unclassified.

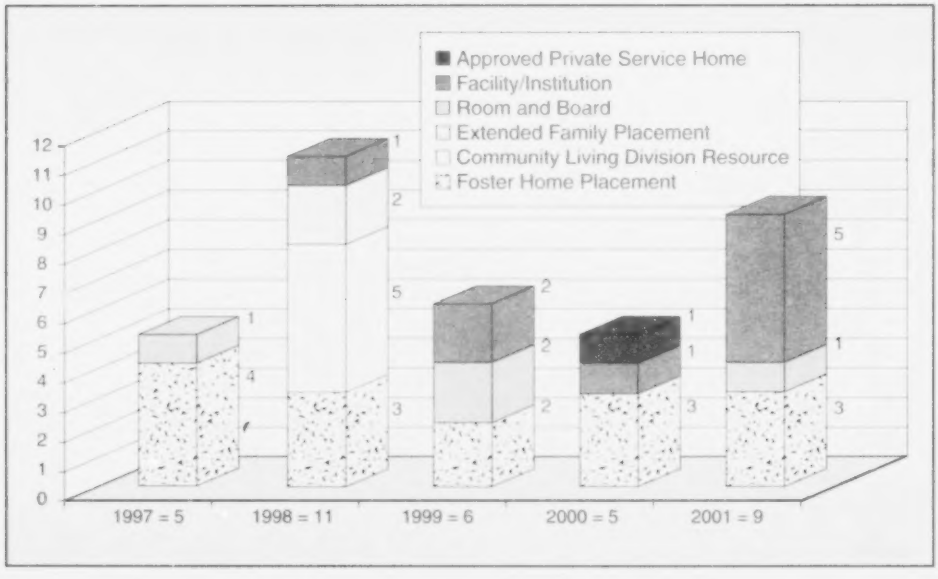
[4] Inconsistencies can arise when data from two different sources are compared. The series of deaths reviewed by the Chief Coroner and the CAO and the data from Vital Statistics are not the same data files. Some factors that may contribute to inconsistencies in data are:

- Potential differences in the level of detailed analysis used by the Coroner and Vital Statistics. Vital Statistics does not conduct detailed analysis of the cause of death reported by the Coroner on the medical certificate of death.
- Potential differences in the methods of classification used. The underlying cause may differ according to other factors relating to the person and circumstances of death. For example, a person who has an illness such as cancer may die in a fall, and the underlying cause will be cancer, rather than fall.
- Potential unavailability of information or delay in obtaining information. In some cases, Vital Statistics may not have the information necessary to complete the cause of death coding.

Children in Care of the Minister

When a family experiences problems that are of a serious nature and safety cannot be ensured within their home, some members may be placed in out-of-home care or in the care of the Minister. A majority of children are placed in foster care. However, others are placed with extended family, in group homes, or residential facilities. A snapshot for the year 2001 indicates that as of March 31, 2001, there were 3219 children in care under *The Child and Family Services Act* (Saskatchewan Community Resources and Employment, personal communications, January 17, 2005). Children's services were offered to 6226 children in 2000 and were offered to 6473 children in 2001 (Saskatchewan Community Resources and Employment, personal communications, January 18, 2005). Youth who are over the age of 16 may choose to live independently. Children are returned home when their families have addressed the risks to safety or the treatment needs. However, there are situations where children and youth remain in care until they are 21 years of age (Saskatchewan Social Services, 2000).

Figure 4. CAO Child Death Reviews showing Living Arrangement at Time of Death for Children in Care of the Minister of Community Resources and Employment 1997, 1998, 1999, 2000, 2001 N=36



Type of Care

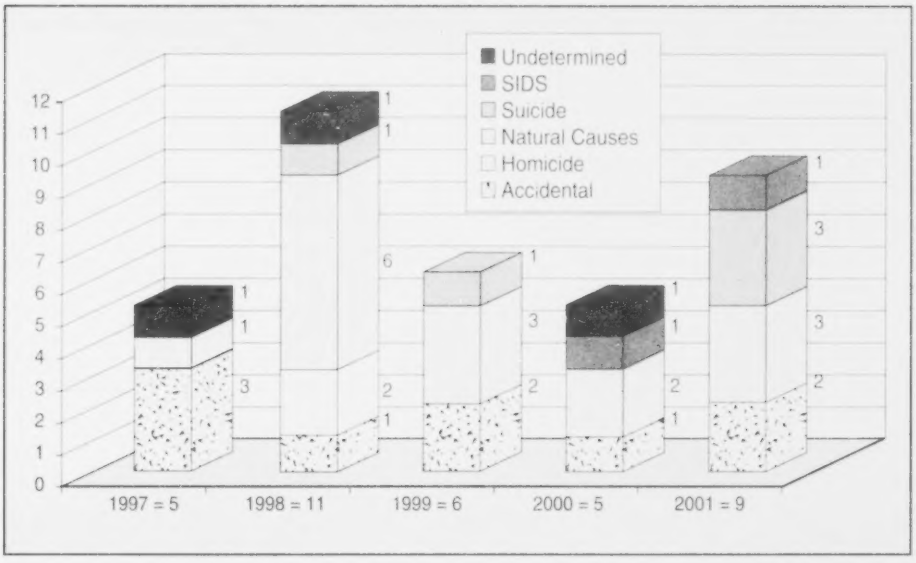
Of the 23 deaths that were reviewed for 2000 and 2001, 14 children were in the care of the Minister of Community Resources and Employment when they died. Figure 4 provides the breakdown of the type of care arrangement for each child.

- six of these children were in DCRE approved foster homes
- three were in hospital
- one was living in a therapeutic group home
- two were living in an open-custody facility
- one was in an approved private service home
- one was a long-term ward living in a room-and-board situation

Cause of Death

Figure 5 provides a breakdown of the cause of death for children living in the care of the Minister of Community Resources and Employment. Of the children who died while living in the care of the Minister, six died of natural causes. Of these six children, two died from pneumonia and the remaining four were medically fragile children that died as a result of preexisting conditions. Two of the 14 children in care died from SIDS; both were living in DCRE approved foster homes. Three deaths were suicides; one youth was living in a therapeutic group home, the second was living in an approved room-and-board placement. The third child was living in an open-custody community home and was AWOL when he committed suicide. All of the three remaining children in care died from accidental causes; one was shot, one drowned, and for one the manner of death was determined to be Fetal Alcohol Syndrome.

Figure 5. CAO Child Death Reviews showing Cause of Death for Children in Care of the Minister of Community Resources and Employment, 1997, 1998, 1999, 2000, 2001 N=36



Children Not in Care of the Minister

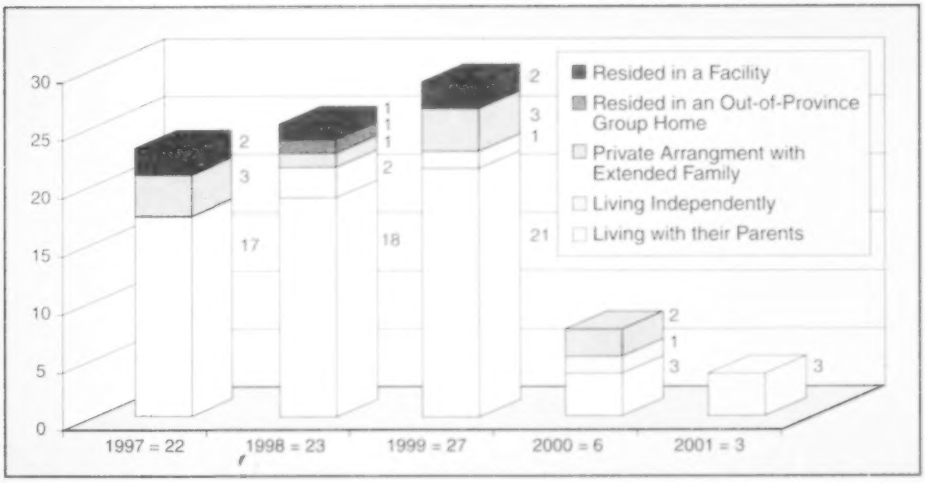
The Department of Community Resources and Employment currently provides services to children and youth residing in their own homes or with extended family. Staff of the DCRE and CPS are engaged in complex human services work with families facing multiple issues such as poverty, addictions, family violence, child abuse and neglect. These services are provided by one or more programs such as Adoption, Child Protection, Community Living Division (CLD), the Teen and Young Parent Program, and the 16/17 year-old program.

From January 1, 2000 to December 31, 2000, child protection services were provided to 9522 families with 22,378 children in those families. From January 1, 2001 to December 31, 2001, child protection services were provided to 9606 families with 22,818 children in those families. (Saskatchewan Community Resources and Employment, personal communications, January 18, 2005). (Note: A complete list of programs available from the DCRE is included in Appendix D.)

For the year 2000, the DCRE provided services to 9746 children/youth receiving services under the Young Offender Program. For the year 2001, the DCRE provided services to 9770 children/youth receiving services under the Young Offender Program (Saskatchewan Community Resources and Employment, personal communications, January 21, 2005). The responsibility for services for young offenders was transferred to the Department of Corrections and Public Safety effective April 1, 2002.

Of the 23 child deaths reviewed for the year 2000 and 2001, nine children were, at the time of their death or in the six months preceding their death, receiving services from the DCRE but were not living in the care of the Minister. Figure 6 provides a breakdown of the type of living arrangement for each of these children. Six were living in their parental home at the time of their deaths, two were living with extended family, one youth was living independently.

Figure 6. CAO Child Death Reviews showing Living Arrangement at Time of Death for Children NOT in the Care of the Minister of Community Resources and Employment, 1997, 1998, 1999, 2000, 2001. N=81[1,2]

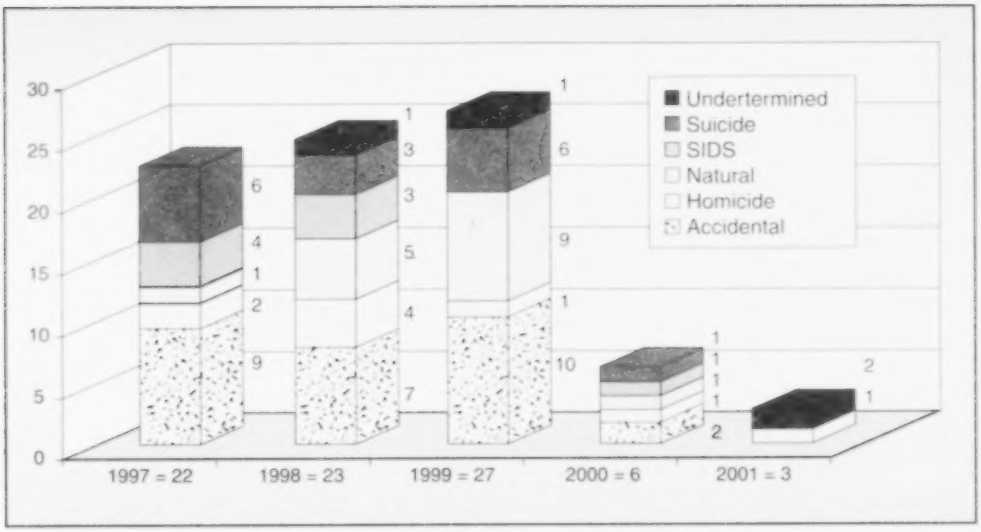


[1] Note: The number of children not in the care of the Minister was increased by 2 for 1999 from the numbers reported in the 1999 Summary Report to reflect the two child death reviews that were concluded since the 1999 Summary Report.
[2] Of the 41 child death reviews that were not conducted by the CAO for the years 2000 (18) and 2001 (23) the following is known: 34 were living with their parents, two were living independently, three were living in a private arrangement with extended family and two resided in a facility.

Figure 7 provides a breakdown of the cause of death for children not living in the care of the Minister at the time of their death. Of the nine children whose deaths were reviewed for the years 2000 and 2001:

- two deaths were classified as Accidental
- two deaths were Homicides (one youth was the one whose residence was unknown)
- one death was a Suicide
- one death was from Natural Causes
- one death was from SIDS
- two deaths were Undetermined

Figure 7. CAO Child Death Reviews showing Cause of Death for Children NOT in the Care of the Minister of Community Resources and Employment, 1997, 1998, 1999, 2000, 2001 N=81[1,2]



[1] Note. The number of children Not in the care of the Minister was increased by 2 for 1999 from the numbers reported in the 1999 Summary Report to reflect the two child death reviews that were concluded since the 1999 Summary Report.

[2] Of the 41 child death reviews that were not conducted for the years 2000 (18) and 2001 (23) the following is known about the classification of deaths: 19 were accidental, 11 were natural, four were suicides, two were homicides, two were SIDS, two were undertermined and the one death was unclassified.

1999 Child Death Reviews

As noted earlier, there are two deaths from 1999 that are included in this report. Neither of these children was in the care of the Minister of DCRE at the time of their deaths. Both were males and both were status First Nations children. Both were living in their parental homes at the time of their deaths. One death was classified as accidental, where the cause was noted as a possible lethal overdose. The other death was determined to be a natural death, where the child died of complications from malutrition after numerous diagnoses of failure to thrive.

Part 7
Issues Relating to Service for Children

Thousands of children and young people each year receive services from government departments and agencies and, for the most part, these children with their families, receive services that are supportive and helpful to them. An external review, such as provided by the CAO, of a small number of child deaths is not a review of the quality of the services provided to these thousands of children and should not be interpreted as such. The quality improvement plan of the DCRE and similar plans implemented in other departments and agencies are more appropriate measures of the compliance by service providers to their own policies and best practices standards.

Having said that, the CAO review of deaths is one way to examine how policies are reflected in practice. The CAO child death reviews continue to provide a measure of public accountability when children, in government care, die. Of the twenty-five child death reviews included in this summary report, the CAO found and reported on eleven deaths where policies were not adhered to and findings or recommendations were made to the appropriate government departments and agencies. In five of the twenty five child death reviews, no specific findings were made regarding compliance with policies. However, concerns regarding the quality of services provided to the children were noted.

In nine of these twenty-five reviews, the CAO found that the level and quality of service provided to the children met or exceeded the legislated requirements and policy standards. The CAO commended the DCRE and others for the excellent care provided to some of these children. The following are examples taken from some of the closing letters of these nine individual child death reviews.

- The CAO found that the DCRE investigation was timely and comprehensive and that DCRE provided child protective services in a culturally respectful and inclusive manner.
- The CAO found that the DCRE services were collaborative, timely, well documented and according to policy.
- The CAO found that the DCRE services demonstrated a proactive approach to ensure the safety of the child.
- The CAO found that the DCRE provided a stable and caring foster family.
- The CAO found that the planning and collaboration between DCRE and various other agencies demonstrated conscientious case practice that was commendable.

As in our previous summary reports, this section of this summary report provides an update on any recurring issues and identifies new issues that emerged from this set of reviews.

Assessment and Intervention

In 13 of the 2000 and 2001 reviews the CAO found that assessments and interventions were conducted in accordance with DCRE policy. The CAO identified concerns regarding assessment and intervention in nine of the twenty-three child death reviews from 2000 and 2001. Concerns regarding assessment and intervention were also present in both of the 1999 child death reviews. The majority of these concerns did not result in recommendations, as policy already exists in this area. The CAO raised the issues as practice concerns.

1999 Findings

In the first 1999 child death review, the CAO identified problems with inadequate assessment by medical professionals. This child had a well-documented history of failure to thrive. On three occasions, a parent contacted a physician to seek medical assistance for the child. Each time, the physician provided medical advice or a prescription without physically examining the child. In addition, other health professionals who provided service to this child did not intervene when it could have been appropriate to do so. The child's health deteriorated to a critical state. The CAO referred this matter to the College of Physicians and Surgeons (College) for review and consultation. The College's conclusion identified the need to work collaboratively to prevent systems from failing children. The CAO reported the findings and conclusions of the College's review to the Health Authority. The Health Authority advised the CAO that they have initiated a Team Case Review process to examine issues outlined in this review and will report on this to the CAO at a future date.

In the second 1999 child death review, the CAO identified problems with inadequate assessment and intervention by a First Nations Child and Family Services (FNCFS) agency. Over a five-year period, the FNCFS agency received numerous child protection referrals regarding this child. In addition, the FNCFS agency received assessments from other professionals, which identified that the actions of the parent placed this child at risk. The FNCFS agency acknowledged that the lack of assessment and intervention permitted an unacceptable situation to persist. The FNCFS agency conducted an internal review and identified internal systemic recommendations to increase accountability and prevent similar concerns in the future. The CAO concurred with the FNCFS agency's findings and recommendations and determined that no further recommendations were required as the FNCFS agency had proactively introduced comprehensive system changes.

2000 and 2001 Findings

In nine of the 2000 and 2001 reviews, the CAO identified problems with assessment and intervention.

Assessment

In three reviews, the CAO identified problems with inadequate assessment at the initial investigation stage. The first of the three reviews involved a severely beaten child who subsequently died. The medical examination at the time of this child's death revealed a history of chronic abuse. Upon notification of this incident, DCRE policy required that the DCRE investigate the safety of the remaining siblings. While the siblings were moved, the CAO review found that the DCRE failed to complete this safety assessment, including an assessment of the parent's ability to provide a safe environment for the children.

In the second review, the DCRE received child protection referrals regarding alcohol abuse, family violence, child abuse and neglect in 1999 and again in 2000. The CAO found that the DCRE did not investigate to assess the children's safety.

In the third review, the CAO identified the need to develop specific assessment and intervention skills to address the unique needs of children of immigrant families. The child in this review had been exposed to war at an early age. The CAO found that the DCRE did not account for this child's post-war trauma, the impact of adapting to a new culture, and the cultural dynamics within the family in assessment or intervention planning. The CAO found that an increased understanding of these issues would have assisted the DCRE and other agencies to be more supportive of this child and the family. As a result of the concerns identified within this review, the CAO recommended:

Recommendation CDR.66(01)[8]
That the Departments of Community Resources and Employment and Corrections and Public Safety forge links with the immigrant community (in named city locations) to assist with providing peer mentoring support to immigrant youth in care.

Recommendation CDR.67(01)[8]
That the Departments of Community Resources and Employment and Corrections and Public Safety ensure that workers receive training on the needs of immigrant children affected by war in their country of origin.

Progress

The DCRE accepted Recommendation CDR.66(01). The DCRE advised that the Complex Needs Committee, an inter-departmental committee, develop case plans for high-needs children. This committee incorporates culture and community when conducting assessments and developing intervention plans. This committee was in existence at the time services were provided to this child; however, this service was not accessed.

The DCRE also accepted Recommendation CDR.67(01) and advised that a Multi-Cultural Risk Assessment tool has been added to the Family Centred Services Manual. The assessment process now requires the caseworker to gather information from various sources to ensure a comprehensive understanding of the child's culture. In addition, the DCRE advised that training regarding the impact of war will be incorporated into the provincial child welfare-training curriculum.

CPS contacted the CAO with respect to recommendations CDR.66(01) and CDR.67(01) and have indicated that they "will work with (DCRE) as appropriate to satisfy the recommendations."

Intervention

In six reviews, the CAO found that the DCRE permitted children to reside in environments where ongoing protection concerns were not addressed, placing the children at risk.

[8] It should be noted that recommendations CDR.66(01) and CDR.67(01) were only sent to the DCRE for a response and not CPS. Therefore, CPS did not have the opportunity to officially respond to these recommendations prior to releasing this report. However, as noted above, CPS has indicated that the department will work with the DCRE to satisfy these two recommendations.

In the first of these six reviews, the CAO found that the DCRE's involvement did not ensure that the child's on-going safety was planned for prior to closing their file. In this situation, a child was placed in the care of extended family members through a private arrangement supported by the DCRE. Once the extended family placement had been established, the DCRE closed their file. The DCRE file closure occurred without providing direction to the extended family members about family contact or reunification and without reassessment of the protection concerns within the parental home. After the DCRE was no longer involved, the the extended family permitted the child to return to the parents' care for a home visit. The protection concerns that led to the DCRE's initial intervention persisted and the child's safety was jeopardized when he visited his parents.

In the second and third reviews, the CAO found that the DCRE returned children to their parents' care when the orginal child protection concerns continued to persist. While a plan was in place to support the return of the children to their mother, the CAO concluded that the DCRE failed to fully assess the risk to the children in their home.

Similarly, in the fourth and fifth reviews, the CAO found that the DCRE returned children without completing a risk assessment to determine if the protection concerns still existed. The DCRE apprehended both of these children again due to the same and ongoing protection concerns. The DCRE policy directs that a risk assessment must occur prior to a child returning home "to determine if there has been sufficient behavior change or altering of conditions to reduce risk and allow the child's return home." In one of these files, the DCRE returned and subsequently apprehended the child on three occasions and did not complete a risk assessment prior to returning the child to his mother's care.

The sixth review was of particular concern. In this review, the CAO found that the DCRE had a long history of child protection concerns in the family. The newborn was released from the hospital to the parent's care despite a chronic history of abuse and neglect and DCRE knowledge that the situation had not improved. The DCRE then received eight child protection referrals during the infant's seven-week, four-day life. During the review, the CAO found no information to suggest that the DCRE conducted a comprehensive assessment of this situation or intervened to protect this infant or the siblings. Given the lack of observable changes in this family system, the chronic history of alcohol-related protection concerns, extreme violence, and multiple inappropriate placements documented on the files reviewed, the CAO determined that the DCRE provided too many "chances" to the parent. This lack of intervention was not in the children's best interest. The CAO found that there was an overall failure by the DCRE to protect this infant and the siblings who continued to reside in an environment that placed them at risk of abuse and neglect. The DCRE disagreed that there was "an overall failure" by their department to protect this infant and acknowledged "that there was not an appropriate assessment of risk." The CAO requested that the DCRE review their quality assurance protocol and advise how current policy and practice will prevent such a death from occurring in the future.

In all six files, the DCRE did not follow best-practice standards outlined in policy. While the principles of strengthening and empowering families and preventing placement of children in foster care are important, the child's best interest and safety must remain the primary concern. This issue was raised in the 1999 Summary Report. As such, the CAO, once again, forwarded recommendation CDR.42.(99):

Recommendation CDR.42(99,00)
That the Department of Community Resources and Employment undertake to regularly identify and review, at a management level, those cases where children are repeatedly subjected to neglect over a significant period of time and where Saskatchewan Community Resources and Employment has frequently re-opened child protection files. This review would be intended to ensure that interventions are "as complete and as intensive as necessary...to bring about needed change to reduce risks and ensure the protection of the child" (Family-Centred Services Manual, Chapter 1, Section 1, p. 2).

Recommendation CDR.68(01)
That when children are placed with extended family (or significant other persons) as a result of a child protection concern, children must be provided with the same level of safety, through appropriate assessments, planning and support systems, as children in other out-of-home placements.

Progress

The DCRE responded to Recommendation CDR.42(99.00) by stating that supervisors are required to conduct systematic case reviews of each file. In addition, the DCRE advised "there are regional processes such as approval of Agreements for Residential Services (Section 9), family support contracts, ward and rate reviews that are approved at a management level." The CAO does not believe that these mechanisms address the issues identified. The CAO continues to pursue this issue with the DCRE.

The DCRE accepted Recommendation CDR.68(01) and advised that the issue will be addressed when the kinship care approach is formalized. The DCRE has assured the CAO that child safety is still their main concern and that they will maintain a role in assessing child safety within the kinship care arrangement. The CAO continues to be informed as the DCRE works towards proclamation and implementation of the kinship care amendments to *The Child and Family Services Act*.

Of note, the DCRE has publicly acknowledged that there is an ongoing need for improvement in the consistent application of the standards of practice and that they are acting to ensure that best practices are in place, implemented and evaluated.

Placements

In eight reviews the CAO found that the DCRE placements for children, who could not remain whith their parents, were appropriate. In four of the 14 2000 and 2001 child death reviews where the children were in the care of the Minister, the CAO identified placement concerns. These reviews involved children who had been placed in the care of the Minister prior to their death. Children who were not in care or were placed in institutions, such as a hospital or a young offender facility, are not included in this section.

Assessment of Risk Factors

In three reviews, the CAO found that the DCRE placed children in resources without adequately evaluating issues within the resource that compromised the care or safety of children.

In two of these reviews, the CAO found that the DCRE placed children in resources where the caregiver had addiction issues. In both of these situations, the DCRE did not assess the caregivers' addiction issues or the impact it had on their ability to provide for the children's needs.

In one of these situations, the DCRE placed a non-verbal foster child in a home shortly after a decision had been made to suspend placements in that same home. The DCRE suspended placements to allow the caregiver time to address her addiction issues and demonstrate a period of stability. However, the DCRE did not reassess to determine if the addiction problem had been addressed. In addition, the CAO review found that the DCRE did not closely monitor the child's placement in this resource, even at a level consistent with minimum contact standards. Similarly, in the second situation, the DCRE placed a troubled youth in a resource where concerns were reported regarding addiction issues of the room and board provider.

In the third review, the CAO found that a child was placed in a foster home without adequate assessment of the safety of the farm environment. In this situation, the child drowned in a lagoon located on the farm. The CAO identified the need to adequately assess the safety of farmyards in the foster home approval process. The Summary Report on Agricultural Injuries in Canada 1990-2000 identified that drowning is one of the three main causes of fatalities on farms for children under 10 years old (Canadian Agricultural Injury Surveillance Program, 2003).

The CAO review found that there is no specific category for farmyard assessment on the Foster Home Safety Checklist used when DCRE approves or annually reviews the safety of foster home premises. In order to promote safe environments for foster children, the CAO forwarded the following recommendation:

Recommendation CDR.73(01)
That the Department of Community Resources and Employment revise the Foster Home Safety Check List to coincide with existing standards in the Children's Services Manual (Chapter 4.4.3) regarding farm safety for children in care.

Progress

The DCRE advised that they accepted the finding that the Foster Home Safety Checklist does not have a specific category to assess the risk regarding the foster home yard. The current check list makes reference to a broader policy, including farm safety, and the DCRE has determined that this checklist is satisfactory and are taking no further action on this recommendation.

Suitability of Placements

In two reviews, the CAO found that the DCRE did not adequately assess the placement to ensure that it would meet the specific needs of the child. Both of these reviews involved children with medical needs. In one review, the DCRE placed a non-verbal child in an Approved Private Service Home (APSH). APSH's are resources that are developed and approved for adult clients of the Community Living Division (CLD) program. These homes were not intended to be resources for children in care. The CAO review identified that the level of service provided to the child and the approval and training requirements of the APSH home, did not meet best-practice standards outlined in the DCRE's Children's Service Manual. The CAO recommended:

Recommendation CDR.69(00)
That the Department of Community Resources and Employment's audit and review of services being provided to children placed in Approved Private Service Homes in relation to the policy standards outlined in the *Children's Services Manual*, be provided to the Children's Advocate Office by March 1, 2005.

Progress

The DCRE concurred with the CAO that APSH's were developed for adults with respective standards of care that reflect adult support needs. The DCRE acknowledged that placing children in resources developed for adults, with corresponding standards of care, is a practice that requires review. Given the concerns, the DCRE agreed to review the placements of the 33 children in Approved Private Service Homes across the province to ensure that their needs are being met. Further, the DCRE agreed to review the practice of placing children in an APSH. The CAO is expecting to receive the results of this DCRE review by March 2005.

Need for Integrated Case Management

Six of the 23 2000 and 2001 child death reviews and both of the 1999 child death reviews identified concerns regarding a lack of integrated case management services. In addition, the CAO found that there was a need for increased communication between the various government departments and agencies involved on each of these reviews.

The Saskatchewan Human Services Integrated Case Management model was developed in 1998 to provide best-practice standards as guidelines to facilitate a collaborative approach to service delivery. These best-practice standards were not applied on these eight files.

1999 Findings

Both of the 1999 child death reviews identified problems with service coordination between agencies.

The first review found that the medical community, the DCRE, Public Health Services, and Aboriginal services did not share information between agencies. This lack of information-sharing between agencies resulted in disjointed service delivery. The CAO referred this file to the College of Physicians and Surgeons. The College concluded that the care and assistance provided to this child and family was provided "in silos" and not in a collaborative fashion. While unintended, this lack of coordination between service providers compromised the quality of care provided to the child.

The other 1999 review identified similar concerns. Health professionals had concerns about parental noncompliance with a child's medication regimen. This non-compliance presented serious health risks for the child. The CAO review found that although the health professionals reported their concerns to an officer pursuant to *The Child and Family Services Act*, the concerns persisted. In addition, the CAO found that health professionals did not report every incident when the parent's non-compliance with the child's medical regimen placed him at risk.

Health professionals are responsible for reporting every incident when a parent's non-compliance with a child's medication regimen may harm a child. The CAO recommended:

Recommendation CDR.70(99)
That the (Named Regional Health Authorities) advise all health professionals that each incident, where they believe a child is in need of protection, needs to be reported to an officer or peace officer pursuant to *The Child and Family Services Act*.

Recommendation CDR.71(99)
That the (Named Regional Health Authorities) advise all health professionals of the Department of Community Resources and Employment's appeal process and that it is available to them if child protection concerns persist despite referrals for intervention.

Progress

The Regional Health Authority accepted both recommendations. The Regional Health Authority advised the CAO that they completed an education session for all staff and physicians. This training session outlined the legislative requirements, policy and procedure for reporting child protection matters. The education session was "televised" to the acute care facilities in the region, as well as the majority of other health regions.

The Regional Health Authority further advised that their reporting process outlines that an acknowledgement of referral letter can be requested from the DCRE to ensure receipt of their initial report. The Health Authority advised staff that every incident where they suspect child abuse or neglect must be reported according to policy and legislation.

2000 and 2001 Findings

In six reviews, the CAO identified the need for increased communication between child-serving departments and agencies.

DCRE and the Provincial Coroner

In one review, the CAO found that there was a need for improved communication between the DCRE and the Provincial Coroner. In this situation, the DCRE received information regarding the circumstances of the child's death after the Coroner had determined the cause and manner of death. The CAO found that this information was not shared with the Coroner. As such, the CAO recommended:

Recommendation CDR.76(00)
That the Department of Community Resources and Employment advise the Coroner's office of the information regarding (Named child's) disclosure to facilitate a Coroner's review of this case and request that he reconsider the classification and sub-classification of death.

Progress

The Coroner conducted a review and changed the classification of death according to the new information provided. The DCRE advised the CAO that it is not their responsibility to provide police investigation information to the Coroner directly, but rather, have the information provided to the Coroner, by the police investigating the circumstances of the death.

DCRE and Health

In two reviews, the CAO found that communication broke down between the DCRE and Health services.

In the first review, the DCRE mistakenly believed that a child in their care was accessing Mental Health services when the child was not. Since the child was in care, it was the responsibility of the DCRE to ensure that adequate services were provided. No recommendations were made in this review.

In the second review, the CAO found that the DCRE case plan directed follow-up with the child's physician to request a referral to a specialist for assessment of symptoms indicative of possible Fetal Alcohol Spectrum Disorder. The CAO review found that this child did not receive this referral and the symptoms went unassessed. On another occasion, an asthma and allergy specialist recommended that this child return in six weeks to assess the effectiveness of his asthma treatment and to plan further management. The CAO found that the DCRE did not follow up with the physician regarding the outcome of this appointment.

Multiple Departments and Agencies

In one review, the CAO found that the DCRE, Health, a Regional Health Authority, CPS, and Learning did not use an integreated case management approach to ensure appropriate delivery of service to the child. In this situation, the CAO found a lack of collaboration, which continued despite the evident deterioration in the child's mental health and school performance. The CAO concluded that this child did not receive the integrated service the child was entitled to and recommended:

Recommendation CDR.49 (99.01)
That the Department of Community Resources and Employment, Corrections and Public Safety, Learning, Health and the Health Authority jointly review the Saskatchewan Human Services Integrated Case Management model and create a process to ensure that it is implemented appropriately, including regular follow-up and review of identified children and youth who require this service.

Progress

The departments and agencies involved accepted Recommendation CDR. 49 (99.01). The CAO was advised by the DCRE that an interdepartmental committee involving DCRE, CPS, Learning, Health and the Health Authority met to review the use of the Saskatchewan Human Services Integrated Case Management Model provincially. The Regional Health Authority advised that an internal review would occur to examine current practice and ensure that the Model is implemented appropriately. The DCRE advised that the interdepartmental committee is updating the 1998 *Integrated Case Management Manual.*

CPS / DCRE and Police Services

In one review, the CAO found that CPS failed to effectively communicate pertinent information to the police service when a youth ran from an open custody placement. In this situation, CPS did not advise the police of the youth's home address when the missing person report was filed. This interfered with locating this young person in a timely manner.

In another review, the CAO found that police officers left small children in the care of people other than the children's parents without notifying the DCRE or Mobile Crisis Service. The police detained the infant's parent due to a domestic disturbance and none of the officers involved were aware of the baby's presence in the home. The officers left this baby and the older siblings in the care of a "3/4 sober" man who they determined was able to care for them while the police detained the parent at the police station. Given the concerns identified in this review, the CAO recommended:

Recommendation CDR.74(00)
That the Department of Community Resources and Employment and (Named Police Service) develop a protocol to ensure that the Department of Community Resources and Employment and/or Mobile Crisis Service are advised in situations where parents have been detained and there are children for whom alternative care arrangements are required.

Progress

With respect to the issue of communication between CPS and police services, the CAO made no recommendations. However, the CPS advised the CAO that a community-safety planning process and a case-management process had been introduced to address this concern.

To address the issue raised by Recommendation CDR.74(00), the DCRE and Police Service advised the CAO that they met regarding the recommendation. The Police Service advised the CAO that they have a newly established internal protocol, falling within the requirements of *The Child and Family Services Act*, outlining that the police will advise DCRE Intake or Mobile Crisis Services of situations where parents have been detained or arrested and alternative care arrangements are required for the children. The Police Service posted a Departmental Notice to remind members of their responsibility under *The Child and Family Services Act*. The Notice specified that "members are reminded that when arresting or removing parents from a home, or when investigating reports of domestic violence, that their actions should be guided by these sections of *The Child and Family Services Act*. Specifically, in the event that children are left with someone other than the parent to look after them, members shall notify DCRE or Mobile Crisis Services Inc."

Information Management

In seven of the 23 2000 and 2001 reviews, the CAO identified problems with information management including sharing information, accessing information, storing information, and recording information.

Sharing Information

In one review, the CAO identified that the DCRE group home staff did not report a suicide attempt by the child to the DCRE worker in a timely fashion. In three other reviews, the CAO identified that the DCRE did not share essential information with foster parents. The CAO forwarded recommendation CDR.38 (99) again, in relation to two of these files:

Recommendation CDR.38(99,00,01)
That foster parents must be provided with information about the children in their care in a timely manner. Foster parents require health status, education, family connections and other information useful to providing daily care as soon as possible.

Progress

The DCRE revised the *Children's Services Manual* to implement recommendation CDR.38(99,00,01). DCRE policy now directs that "all relevant information shall be provided to the caregiver preceding or upon the child's placement in out-of-home care." The DCRE implemented the use of a Caregiver Information Form to provide caregivers with written information. Ensuring that foster parents have complete information with regard to the children's health, education, and family needs is a positive step towards providing quality care for children in foster care.

Accessing Information

In one review, the DCRE experienced problems accessing historical information from another provincial child welfare department. The CAO recommended:

Recommendation CDR.64(00)
That the Department of Community Resources and Employment clarify with (the provincial child welfare department) the process to be used to ensure that written information regarding children in need of protection is shared in an appropriate and timely manner.

Progress

The DCRE accepted the CAO recommendation and acknowledged that it is important to review the efficiency of the inter-provincial protocols. The DCRE identified that First Nations Child and Family Services authorities also need to be included in co-coordinating inter-provincial child welfare services agreements. The DCRE advised that they brought the issues identified in the CAO review to the attention of the National Directors of Child Welfare in October 2004. Further, the DCRE advised that the National Directors of Child Welfare are forming a working group to develop guidelines to operationalize the inter-provincial protocol.

Storing Information

In two reviews, the CAO found that information was not available for review. In one situation, the Regional Health Authority advised the CAO that a youth's Addictions Services file was "probably destroyed." Destroying these records contradicted the policy of the Regional Health Authority and the *Youth Criminal Justice Act*. In the second review, the DCRE lost nearly all documentation on a file from the time of the mother's pregnancy until the child's death. The CAO independently reconstructed a record of services provided to the child by gathering information from departments and agencies that had provided services to this child and family. The CAO review found that the DCRE's reconstructed file was incomplete and did not provide a comprehensive picture of the events that transpired between this child's birth and death. The CAO noted that the DCRE continued to offer family services based on incomplete file information. The CAO recommended:

Recommendation CDR.72(00)
That the (Named Regional Health Authority) develop policies and train appropriate staff regarding handling of records under the *Youth Criminal Justice Act*.

Recommendation CDR.75(00)
That the Department of Community Resources and Employment develop a policy regarding file reconstruction in situations where files are lost.

Progress

The Regional Health Authority advised the CAO that Addiction Services no longer destroy the assessment files of young offenders. Further, the Regional Health Authority is collaborating with the Department of Health to develop policy to ensure that the management of assessment files is done in accordance with the *Youth Criminal Justice Act*.

The DCRE has accepted Recommendation CDR.75(00) and has advised that "a policy on file reconstruction is being developed for inclusion into the Family Centred Services Manual."

Recording Information

In one review, the DCRE failed to register a child abuse referral on the DCRE's Automated Client Index system. As a result, information regarding the history of protection concerns in the family was not accurately recorded. This was of particular concern to the CAO because if further child protection concerns are made about these individuals, there would be no record of the earlier concerns. Therefore, the CAO recommended:

Recommendation CDR.65(01)
That the Department of Community Resources and Employment register the abuse referral regarding this family on the Automated Client Index system.

Progress

The DCRE reported that the incident resulting in this child's death has now been included on the Automated Client Index system.

Medical Services

In one review, the CAO identified systemic concerns regarding diagnostic imaging when multiple hospitals are involved. The review of services provided to this child identified areas that could be improved to better ensure comprehensive service delivery for children. Given the medical service concerns observed, the CAO referred this file to the College of Physicians and Surgeons. Upon conclusion of the College's review, the CAO recommended the following:

Recommendation CDR.77(01)
That Saskatchewan Health and the (Named Regional Health Authority) work with the College of Physicians and Surgeons to implement systemic changes to address the issues identified in the review of services provided to (Named).

Progress

The Regional Health Authority accepted this recommendation and contacted the College of Physicians and Surgeons. The Regional Health Authority advised the CAO that the Regional Health Authority, Saskatchewan Health representatives and the College of Physicians and Surgeons are developing a collaborative approach to address systemic changes related to x-ray studies on a provincial basis.

Part 8
The Future

This is the third Summary Report prepared by the Children's Advocate Office in relation to the deaths reviewed by our Office. This continues to be a very challenging part of our work. We believe that having completed 117 independent child death reviews provides us with a very important perspective into child-serving systems. The CAO is committed to continuing to complete comprehensive independent reviews of the deaths of children who were in government care. This includes those children in foster or group home care, or those receiving residential support services such as young people aged 16 and 17 who are living independently, or youth in conflict with the law who are in a secure or open custody facility. As this process evolves, it will be important to determine how deaths of children living in kinship or alternative home placements and how the deaths of children receiving services from First Nations Child and Family Services Agencies will be regularly reviewed. These are issues for future examination.

In December 2003, the CAO released *A Summary of Child Deaths for the Year 1999*. In the report the CAO identified a number of options for changing the child death review processes in Saskatchewan.

File Audits to Review Compliance with Case Practice

One of the major issues repeatedly identified by the CAO in our review of many of these child deaths are those concerns related to case practices. As in the 1999 Summary Report, the CAO continued to observe gaps between government policy and practice in these deaths from 2000 and 2001.

In December 2003, when the CAO released the summary report on the 1999 deaths, the CAO requested that the Department of Community Resources and Employment provide the CAO with the results of their annual file audits. The CAO also requested that the DCRE publicly release the results of these file audits. The Provincial Auditor also made a similar recommendation for improved quality assurance processes to the DCRE in December 2003. The DCRE has subsequently developed and implemented a very comprehensive and commendable Quality Improvement Plan that was endorsed by the Provincial Auditor in June 2004. The DCRE reported some general trends in their compliance results (increases and decreases) for 2003 in their 2003-2004 Annual Report. The measures taken to date are moving towards the increased transparency and accountability that the CAO requested of the DCRE in 2003. The CAO is hopeful that more specific results will be reported publicly in upcoming Annual Reports.

The CAO supports the DCRE's efforts to create and sustain a culture of continuous improvement and to achieve excellent case practices and increased accountability through public reporting. There is a need for continued vigilance in relation to quality assurance processes to ensure that children and their families do, indeed, receive the services they require for their safety and well-being.

Review All Child Deaths

In the 1999 Summary Report, in accordance with *The Ombudsman and Children's Advocate Act*, the CAO recommended: "That government develop a model to ensure all child deaths are reviewed by 'an educated eye' and that this model begin to be implemented by January 1, 2005."

To date, there is still no mechanism in Saskatchewan to review the deaths of all children. However, the Saskatchewan government has shown a commitment to developing a process for the gradual implementation of an all child death review process.

Saskatchewan Health funded a Child Death Review Forum in March 2004. The forum was organized and facilitated by the Saskatchewan Institute on the Prevention of Handicaps (Institute) in partnership with the College of Physicians and Surgeons and the Children's Advocate Office. Stakeholders from across the province and invited guests discussed an "all-death" review model for Saskatchewan. Based on the results of the Forum, the Institute produced a draft model and process for the review of all child deaths. This information was provided to Saskatchewan Health and distributed to the Forum participants.

Saskatchewan Health has indicated to the CAO that they "will continue to work in partnership with other Departments and agencies: to more fully explore the operational, jurisdictional and legislative implications of an expanded child death review; to consider the mandates and roles of the Chief Coroner's Office and the Children's Advocate Office in that respect; and to assess the extent to which the additional information obtained through an expanded review will contribute to the objective of reducing children's deaths."

In Closing

These child deaths are a sobering reminder of the need to ensure that Saskatchewan child-serving systems are effective, and that all of us respond appropriately to ensure that our children are safe and well cared for. The CAO recognizes that this important work, while difficult, provides an opportunity to refect upon the services children receive and to promote improvements to services that may prevent similar deaths in the future.

Appendix A

Children's Advocate Office Multi-Disciplinary Review Team

The Multi-Disciplinary Review Team (MDRT) is comprised of individuals who were invited to participate due to the expertise and perspective they brought to the reviews. Special appreciation is extended to the following members of the MDRT who participated in the review of the 2000 and 2001 child death reviewsm, and who gave of their time and expertise to improve the delivery of services to children in Saskatchewan.

Mr. Don Bird
Dr. Pat Blakley
Ms. Darlene Domshy
Mr. Bob Green
Dr. Gord Kasian
Mr. Murray Langaard
Mr. Ron Pollock
Mr. Kent Stewart

Appendix B

Provincial/CAO Comparison of Child Deaths

Table 1. Deaths of Children From Birth to 21 Years of Age in Saskatchewan: CAO Deaths Reviewed and Total Provincial Deaths[1], 1997 to 2001

Official Classification of Death	Year	TOTAL Deaths Birth to 21 Years	CAO Death Reviews	Deaths NOT Reviewed
Natural	1997	126	2	N/A
	1998	116	12	N/A
	1999	105	10	N/A
	2000	98	3	7
	2001	86	3	6
SIDS[2]	1997	6	4	N/A
	1998	13	3	N/A
	1999	12	1	N/A
	2000	10	2	
	2001	6	1	
Accidental	1997	75	12	N/A
	1998	55	8	N/A
	1999	70	11	N/A
	2000	68	3	6
	2001	63	2	13
Suicide	1997	19	6	N/A
	1998	25	3	N/A
	1999	12	7	N/A
	2000	17	1	4
	2001	15	3	
Homicide	1997	6	2	N/A
	1998	5	6	N/A
	1999	2	1	N/A
	2000	4	1	
	2001	7	1	2
Undetermined	1997	2	1	N/A
	1998	1	1	N/A
	1999		1	N/A
	2000	1	1	1
	2001	6	2	1
TOTAL	1997	234	27	N/A
	1998	215	33	N/A
	1999	201	31	N/A
	2000	198	11	18
	2001	183	12	22[3]

[1] Source: Saskatchewan Health, Corporate Information and Technology Branch (Provincial data for 1997, 1998, 1999 prepared with the assistance of the Saskatchewan Institute on Prevention of Handicaps, 2003.) Source for 2000 and 2001 provincial data was the Saskatchewan Vital Statistics Interim Data Set provided by Saskatchewan Health, Health Information Solutions Centre (February 2005) and includes deaths of Saskatchewan residents, aged 21 and under, occurring in Saskatchewan.

[2] For provincial data, includes sudden deaths of infants, cause unknown.

[3] The total number of deaths where the CAO received notification of the death, but did not review the death due to the change in the DCRE policy was actually 23. One death does not appear in the table as it was Unclassified.

[4] Deaths of Saskatchewan residents occurring in other provinces are not included. Deaths of non-Saskatchewan residents occurring in Saskatchewan are not included. A discrepancy occurred for the Homicide deaths of children aged 1-5 years in 1997 and aged 16-17 years in 1998, and for Undetermined deaths of children under one year in 1998 and 1999.

[5] Inconsistencies can arise when data from two different sources are compared. The series of deaths reviewed by the Chief Coroner and the CAO and the data from Vital Statistics are not the same data files. Some factors that may contribute to inconsistencies in data are:

- Potential differences in the level of detailed analysis used by the Coroner and Vital Statistics. Vital Statistics does not conduct detailed analysis of the cause of death reported by the Coroner on the medical certificate of death.
- Potential differences in the methods of classification used. The underlying cause may differ according to other factors relating to the person and circumstances of death. For example, a person who has an illness such as cancer may die in a fall, and the underlying cause will be cancer, rather than fall.
- Potential unavailability of information or delay in obtaining information. In some cases, Vital Statistics may not have the information necessary to complete the cause of death coding.

Appendix C

Children's Advocate Office
Child Death Review Recommendations

The CAO has reviewed the deaths of 117 children who died between August 1996 and December 31, 2001. The CAO has made 77 recommendations in the review of these deaths. Below is the list of all the recommendations made by the CAO to government from the review of child deaths, with the exception of the 27 recommendations (CDR.1-27(97)) made in the review of the death of Karen Quill. The 17 recommendations (14 new recommendations) that have been made by the CAO, with respect to the 25 child death reviews included in this report, have been noted in the margin.

The DCRE, CPS and other government departments and agencies respond to the recommendations made by the CAO. In the majority of cases the recommendations are either implemented or other actions are taken to address the issues identified.

Each CAO recommendation is numbered in succession with the year that the recommendation is made noted in brackets. If the same recommendation is made on more than one file, or in more than one year, it is given the same CDR number and the new year is added; for example, CDR.31(97,99). (Note: where a recommendation contained information that would identify the child, the information was removed from the public recommendation. For a complete listing of the recommendations from the Karen Quill report, please contact the Children's Advocate Office or see the CAO website at www.saskcao.ca.)

CDR.28(97)
That the Departments of Social Services and Health establish a clear protocol for collaborative case planning for children and youth who are receiving services from both departments. It is further recommended that this protocol include a mechanism for review and follow-up to ensure that the needs of the child or youth are being appropriately addressed.

CDR.29(97)
That the Department of Social Services develop policy that outlines the department's responsibility for court ordered undertakings, particularly when these relate to the requirements to provide supervision to youth who are in the care of the Minister.

CDR.30(97)
That the Department of Social Services ensure that the policy and practice specified in the Family Centred Services Manual is complied with. In particular, that the Department of Social Services take steps to ensure that children who remain in the care of their family are protected within that family unit when there are known risks to the child.

CDR.31(97)
That the Department of Social Services include a section on medical care and drug administration (including both prescription and non-prescription drugs), in the pre-service training provided to foster parents.

CDR.32(97)
That the Department of Social Services create an accountable method for all foster parents to record and track all medical care and drug administration. Further, that in the event of a change in placement, that this information is transferred with the child and that a copy is maintained on the Child Care file.

CDR.33(97)
That the Department of Social Services provide all foster parents with training and support to assist them in caring for children with special needs resulting from Fetal Alcohol Syndrome and Fetal Alcohol Effects and that this training becomes mandatory.

CDR.34(97)
That the Department of Social Services review their policy regarding the babysitting of children in the care of the Minister with respect to ensuring that the standards reflect a suitable level of safe care.

CDR.35(98)
That the Intersectoral Committee established to review the recommendations of the March 8-10, 1999 Public Coroner's Inquest into the death of this child complete its review and provide a report to the Coroner and the Children's Advocate by no later than September 2003. In addition, that future reviews of this nature be completed within a specified timeline.

CDR.36(98)
That a review of the need for a residential psychiatric facility for children and youth in Saskatchewan be completed.

CDR.31(97,99)
That the Department of Social Services include a section on medical care and drug administration (including both prescription and non-prescription drugs) in the pre-service training provided to foster parents (previously recommended in a 1997 death).

CDR.32(97,99)
That the Department of Social Services create an accountable method for all foster parents to record and track all medical care and drug administration. Further, that in the event of a change in placement, that this information is transferred with the child and that a copy is maintained on the Child Care file.

CDR.37(99)
That children in care have up-to-date, accurate records that provide complete information about all aspects of the care they are receiving. These records must include a detailed plan for care that incorporates health and educational status. Children must also have access to the personal information that is kept about them. (CYICR 2.8)

REPEAT CDR.38(99,00,01)
That foster parents must be provided with information about the children in their care in a timely manner. Health status, education, family connections and other information useful to providing daily care is required by foster parents as soon as possible. (CYICR 2.9)

CDR.39(99)
That children in care have their health needs carefully assessed, monitored, and fully documented. The full range of health services that parents provide to their children must be maintained by government as parent, including regular health check-ups, up-to-date immunizations, dental check-ups and follow-up, as well as any specialized care required, such as eyeglasses, mental health counselling or orthodontic work. (CYICR 5.4)

CDR.40(99)
That every child care plan include a plan to ensure that the educational needs of that child are being met, including special educational needs of hard-to-serve children. *The Education Act*, 1995, outlines the responsibility of boards of education to provide children in care with an appropriate education. There must be careful documentation of all education progress to ensure continuity when children move or are returned home. Social Services and Education must co-ordinate efforts to ensure that the educational needs of children in care are a priority. (CYICR 5.5)

CDR.41(99)
That the Department of Social Services ensure that the specialized services required for children diagnosed with FAS or other conditions related to prenatal exposure to alcohol be carefully and thoroughly detailed utilizing a multi-disciplinary strategy routinely provided to children in care diagnosed with these conditions.

REPEAT CDR.42(99.00)
That Saskatchewan Community Resources and Employment undertake to regularly identify and review, at a management level, those cases where children are repeatedly subjected to neglect over a significant period of time and where Saskatchewan Community Resources and Employment has frequently re-opened child protection files. This review would be intended to ensure that interventions are "as complete and as intensive as necessary... to bring about needed change to reduce risks and ensure the protection of the child" (Family-Centred Services Manual, Chapter 1, Section 1, p. 2).

CDR.43(99)
That the Department of Social Services provide parents and caregivers of disabled children with assistance, including a comprehensive and current listing of available services, to access a full range of services for their children, including respite services.

CDR.44(99)
That the Department of Social Services review their Family-Centred Services Manual and ensure that inter-provincial information is accessed as an integral part of the investigative process when it is known that the family has a Family Services history in another jurisdiction.

CDR.45(99)
That the Action Plan for Children ensure that information about the dangers of adults co-sleeping with infant children, particularly when intoxicated, be provided to all new parents.

CDR.46(99)
That the Department of Social Services undertake a review of *The Child and Family Services Act*, in relation to other provincial jurisdictions, to determine whether there is a need for enhanced intervention in situations where children are exposed to domestic violence.

CDR.47(99)
That the Department of Social Services ensure that children placed in long-term residential facilities receive, in accordance with policy and best-practice standards, the same level of contact and service that they would be afforded in a foster home or in other out-of-home placements.

CDR.48(99)
That the Department of Social Services develop a directive or policy in the 16/17 Year-Old Program Policy and Procedures Manual pertaining to contact standards with service recipients.

REPEAT CDR.49(99,01)
That the Department of Social Services, Saskatchewan Health and the Regional Health Authorities (Child and Youth Psychiatry Services and Addictions Services) jointly review the Saskatchewan Human Services Integrated Case Management model and create a process to ensure that it is implemented appropriately, including regular follow-up and review of identified children and youth requiring this service.

CDR.50(99)
That the Department of Social Services work collaboratively with Saskatchewan Health and the Regional Health Authorities to provide information to health professionals regarding the philosophy and principles behind Family Centered Case Management and the importance of collectively involving parents in case planning.

CDR.51(99)
That the Department of Social Services provide information to Saskatchewan Health and the Regional Health Authorities regarding the rights and entitlements of parents or legal guardians of children in care under the various provisions of *The Child and Family Services Act*.

CDR.52(99)
That the Department of Social Services incorporate into policy a practice standard of advising health professionals of the legal status of any child in the care of the Minister and provide direction in regard to whom medical information is to be released.

CDR.53(99)
That minimum contact standards are established with respect to the supervision of young persons placed on community dispositions.

CDR.54(99)
That the policy regarding the supervision of dual orders (youth and adult orders) be clarified.

CDR.55(99)
That the Department of Corrections and Public Safety amend the Young Offender Program, Policy and Procedures Manual (1994) to include a mandatory assessment of the youth's alcohol and drug use as a section of the initial assessment and case plan.

CDR.56(99)
That a supervision case plan for Young Offender Orders be made mandatory.

CDR.57(99)
That Saskatchewan Health work with Saskatchewan Environment and other key partners in the north to identify opportunities to educate the public on the potential hazards of toxic plants that grow in the north and to implement such measures as appropriate.

CDR.58(99)
That the Department of Learning address the concern of children not in school (Hidden Youth) by developing and implementing "a new student data system with the capacity to identify and track student enrolment, movement and retention" as agreed to in *Securing Saskatchewan's Future*, the Provincial Response — Role of the School Task Force, Final Report (February 2002, page 12).

CDR.59(99)
That the Department of Learning address the concern of inconsistent and incomplete information on education files that are transferred between schools. This would require developing and implementing a minimum expectation and protocol for transferring information, documentation, and assessments when a child changes schools. In addition, professional development for Administrators throughout the province would need to occur to foster understanding of the importance of forwarding key information. Consistency in the transfer of documentation would enhance the "new student data system with the capacity to identify and track student enrolment, movement and retention" as agreed to in *Securing Saskatchewan's Future*, the Provincial Response — Role of the School Task Force, Final Report (February 2002, page 12).

CDR.60(99)
That the Department of Learning create a "broad-based committee to examine the issue of court orders and school attendance, with the view to clarifying the policies, protocols and communications responsibilities around this issue; and, that the results of its deliberation be published widely." (Final Report, Recommendation 11, page 121).

CDR.61(99)
That the Government of Saskatchewan ensure that post-mortem examinations of children are performed by pathologists who have expertise in pediatric pathology.

CDR.62(99)
That (the) District Health undertake to offer (the child's) biological parents genetic counselling.

CDR.63(99)
That government develop a model to ensure all child deaths are reviewed by "an educated eye" and that this model begin to be implemented by January 1, 2005.

NEW CDR.64(00)
That the Department of Community Resources and Employment clarify with (the provincial child welfare department) the process to be used to ensure that written information regarding children in need of protection is shared in an appropriate and timely manner.

NEW CDR.65(01)
That the Department of Community Resources and Employment register the abuse referral regarding this family on the Automated Client Index system.

NEW CDR.66(01)
That the Departments of Community Resources and Employment and Corrections and Public Safety forge links with the immigrant community (in named city locations) to assist with providing peer mentoring support to immigrant youth in care.

NEW CDR.67(01)
That the Departments of Community Resources and Employment and Corrections and Public Safety ensure that workers receive training on the needs of immigrant children affected by war in their country of origin.

NEW CDR.68(01)
That when children are placed with extended family (or significant other persons) as a result of a child protection concern, children must be provided with the same level of safety, through *appropriate assessments, planning and support systems*, as children in other out-of-home placements.

NEW CDR.69(00)
That the Department of Community Resources and Employment's audit and review of services being provided to children placed in Approved Private Service Homes in relation to the policy standards outlined in the *Children's Services Manual*, be provided to the Children's Advocate Office by March 1, 2005.

NEW CDR.70(99)
That the (Named Regional Health Authorities) advise all health professionals that each incident where they believe a child is in need of protection, needs to be reported to an officer or peace officer pursuant to *The Child and Family Services Act*.

NEW CDR.71(99)
That the (Named Regional Health Authorities) advise all health professionals of the Department of Community Resources and Employment's appeal process and that it is available to them if child protection concerns persist despite referrals for intervention.

NEW CDR.72(00)
That the (Named Regional Health Authority) develop policies and train appropriate staff regarding handling of records under the *Youth Criminal Justice Act*.

NEW CDR.73(01)
That the Department of Community Resources and Employment revise the Foster Home Safety Check List to coincide with existing standards in the Children's Services Manual (Chapter 4.4.3) regarding farm safety for children in care.

NEW CDR.74(00)
That the Department of Community Resources and Employment and (Named Police Service) develop a protocol to ensure that the Department of Community Resources and Employment and/or Mobile Crisis Service are advised in situations where parents have been detained and there are children for whom alternative care arrangements are required.

NEW CDR.75(00)
That the Department of Community Resources and Employment develop a policy regarding file reconstruction in situations where files are lost.

NEW CDR.76(00)
That the Department of Community Resources and Employment advise the Coroner's office of the information regarding (Named child's) disclosure to facilitate a Coroner's review of this case and request that he reconsider the classification and sub-classification of death.

NEW CDR.77(01)
That Saskatchewan Health and the (Named Regional Health Authority) work with the College of Physicians and Surgeons to implement systemic changes to address the issues identified in the review of services provided to (Named).

Appendix D

Services Available to Children Not in the Care of the Minister of Community Resources and Employment

The DCRE provides services to children and youth residing in their own homes or with extended family. These services may include the services provided by one or more programs such as Adoption, Child Protection, Community Living Division (CLD), Teen and Young Parent Program, 16 and 17 year-old Program, Young Offender Programs. (Note: This list of programs was provided to the CAO by the DCRE for the Summary of Child Death Reviews: August 1996 to December 1998. See below for a description of these programs.)

Adoption Services assist and support families who apply to establish a legal family relationship or "adopt" a child.

Child Protection (From January 1, 2000 to December 31, 2000, child protection services were provided to 9522 families with 22,378 children in those families. From January 1, 2001 to December 31, 2001, child protection services were provided to 9606 families with 22,818 children in those families.). Services are provided to families when a child is found to be in need of protection as defined by section 11 of *The Child and Family Services Act*. This includes situations of physical, sexual or psychological abuse, failure to provide essential medical treatment, failure to address serious developmental needs, domestic violence, child abandonment and children under 12 years who commit an offence.

In the majority of situations, the DCRE works with families who are caring for their children in their own homes to improve the quality of parenting and ensure safety. When a family experiences problems that are of a serious nature and safety cannot be ensured within their home, they may be placed in the care of the Minister.

In addition, 17 Indian Child and Family Services Agencies are in operation across the province and provide child protection services to First Nations children and families living on-reserve.

Community Living Division (CLD) The CLD provides services to families who are caring for children and youth with intellectual disabilities. Programs support the physical, emotional, and social needs of clients and assist them to live and function as independently as possible within their own communities.

Teen and Young Parent Program (For 2000, services were provided to 1008 youth; for 2001 services were provided to 933 youth.) This is a voluntary program that assists young adults who are pregnant or parenting children.

Young Offender Programs (For 2000, services were provided to 9746 youth and for 2001, services were provided to 9770 youth.) Services are provided to youth 12 to 17 years of age who have been convicted of a criminal offence and sentenced to a period of probation or custody. The program consists of secure and open custody as well as community-based programs. Youth may remain involved in the program beyond the age of 18 if their period of probation or custody has not been completed.

16 and 17-Year-Old Program (For 2000, services were provided to 2300 youth; for 2001 services were provided to 2381 youth.) The program assists youth to gain independence and provides counselling and residential services to youth that are at-risk. The program combines child welfare, youth programming and income security.

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